**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

TOMBALL REGIONAL HOSPITAL
605 HOLDERRIETH BLVD
TOMBALL TX 77375-6445

**Respondent Name**
AMERICAN INTERSTATE INSURANCE COMPANY

**Carrier's Austin Representative Box**
Box Number 1

**MFDR Tracking Number**
M4-09-5857-01

**MFDR Date Received**
February 2, 2009

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Tomball Regional Hospital appealed for additional payment of reimbursement based on the network accessing per their EOB for additional amount of $14,849.21 minus their previous payment of $285.62. We received a response with additional payment of 99 cents. . . . Tomball Regional Hospital is disputing about paid by American Interstate Co and requesting an additional payment of $14607.60."

**Amount in Dispute:** $14,562.60

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "the charges denied are not reimbursable in an outpatient setting or were included in another procedure on the same day."

**Response Submitted by:** American Interstate Insurance Company

## *SUMMARY OF FINDINGS*

| Date(s) of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| July 1, 2008 | Outpatient Hospital Services | $14,562.60 | $2,679.72 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).

- 100 – ANY NETWORK REDUCTION IS IN ACCORDANCE WITH THE NETWORK REFERENCED ABOVE.
- 113-001 – NETWORK IMPORT RE-PRICING – CONTRACTED PROVIDER
- 58 – Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
- 729-001 – THIS SERVICE IS NOT REIMBURSABLE IN A HOSPITAL OUTPATIENT SETTING.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 243 – THIS PROCEDURE HAS BEEN INCLUDED IN ANOTHER PROCEDURE PERFORMED ON THE SAME DAY.
- W1 – Workers Compensation State Fee Schedule Adjustment
- 595-001 – THE REIMBURSEMENT AMOUNT IS BASED ON THE MEDICARE REIMBURSEMENT PLUS THE PERCENTAGE INCREASE SPECIFIED BY THE STATE.

**Issues**

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

**Findings**

1. The insurance carrier reduced or denied disputed services with reason codes 45 – "Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability)"; 100 – "ANY NETWORK REDUCTION IS IN ACCORDANCE WITH THE NETWORK REFERENCED ABOVE"; and 113-001 – "NETWORK IMPORT RE-PRICING – CONTRACTED PROVIDER." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee agreement between the parties to this dispute. Nevertheless, on November 2, 2010, the Division requested additional information from the respondent pursuant to 28 Texas Administrative Code §133.307(e)(1), which states that "The Division may request additional information from either party to review the medical fee issues in dispute. The additional information must be received by the Division no later than 14 days after receipt of this request. If the Division does not receive the requested additional information within 14 days after receipt of the request, then the Division may base its decision on the information available." The Division requested the respondent to provide a copy of the referenced contract(s) to support that the disputed services were subject to a contractual fee arrangement, as well as documentation to support that the health care provider had been notified that the insurance carrier had been granted access to any alleged contractual fee arrangement between a network and the health care provider. Review of the submitted information finds no documentation to support a contract between the insurance carrier and the health care provider. Although, the respondent did submit a copy of an alleged contract between the health care provider and the network referenced on the explanation of benefits, no documentation was submitted to support that the insurance carrier, American Interstate Insurance Company, had been granted access to the contractual fee arrangement between the health care provider and the alleged network. The respondent did not submit a copy of a contract between the network and the insurance carrier to support that the insurance carrier was an eligible "payor" or insurer "under contract" as required by the terms of the health care provider's alleged contract with the network. The respondent did not submit documentation to support that the health care provider had been notified that the insurance carrier was an eligible or contracted payor under the terms of the provider's alleged contract, prior to the time the services were rendered. The respondent did not submit documentation to support that the injured employee was an eligible "claimant" or "a person covered under workers' compensation coverage that utilizes [the alleged network] as its Certified WCHCN and Voluntary/Informal network" in accordance with the terms of the alleged contract. Further, review of the alleged contract finds that the initial term of the hospital's participation in the alleged network had expired prior to the date of service in dispute, and no documentation was found to support that the alleged contract was in effect on the disputed date of service. Moreover, the attached fee schedule is labeled with the name of an entirely different provider of service, unrelated to the parties in this dispute. Additionally, each page of the submitted fee schedule is stamped diagonally across the page, in bold, with the words "Converted – Does not represent current contract Terms & Conditions." The respondent has failed to support that the submitted fee schedule was applicable to the health care provider or the services in this dispute. No documentation was found to support any specific contractual fee arrangement that would have been applicable to the health care provider and the services in this dispute. No documentation was found to support that the insurance carrier was entitled to access any contractual fee arrangement that would have been applicable to the services in dispute. The Division therefore concludes that the respondent has failed to support that the disputed services are subject to a contractual fee arrangement. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code A4615 has a status indicator of Y, which denotes non-Implantable durable medical equipment not paid under OPPS. Reimbursement is not recommended.
   - Procedure code A4618 has a status indicator of Y, which denotes non-Implantable durable medical equipment not paid under OPPS. Reimbursement is not recommended.
   - Procedure code A6223 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(d)(1). The fee listed for this code in the Medicare DMEPOS fee schedule is $2.42. This amount multiplied by 2 units is $4.84. 125% of this amount is $6.05
   - Procedure code C1769 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code C1713 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75
   - Procedure code 80050 has a status indicator of E, which denotes non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.
   - Procedure code 86701 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $12.41. 125% of this amount is $15.51
   - Procedure code 71020 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 260, which, per OPPS Addendum A, has a payment rate of $44.29. This amount multiplied by 60% yields an unadjusted labor-related amount of $26.57. This amount multiplied by the annual wage index for this facility of 0.9997 yields an adjusted labor-related amount of $26.56. The non-labor related portion is 40% of the APC rate or $17.72. The sum of the labor and non-labor related amounts is $44.28. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.197.

This ratio multiplied by the billed charge of $334.66 yields a cost of $65.93. Per Medicare payment policy, as specified in 42 Code of Federal Regulations §419.43 and *Medicare Claims Processing Manual*, CMS Publication 100-04, Chapter 4, §10.7.1, The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $44.28 divided by the sum of all APC payments is 99.42%. The sum of all packaged costs is $2,883.56. The portion of packaged costs allocated to this service is $2,866.73. This amount added to the service cost yields a total cost of $2,932.66. The total cost of this line item exceeds the annual fixed-dollar threshold of $1,575. The amount by which the cost exceeds 1.75 times the OPPS payment is $2,855.17. 50% of this amount is $1,427.59. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is $1,471.87. This amount multiplied by 200% yields a MAR of $2,943.73.

- Procedure code 76000 has a status indicator of Q, which denotes conditionally packaged services that may be separately payable only if OPPS criteria are met. Payment for this service is included in the payment for any other paid services with status indicators S, T, V, or X billed on the same claim. Payment for this service is therefore packaged with procedure code 71020 with status indicator of X, performed on the same date of service. The use of a modifier is not appropriate. Separate payment is not recommended.
- Procedure code 27536 has a status indicator of C, which denotes inpatient procedures not paid under OPPS. The requestor did not meet the requirements as set forth in 28 Texas Administrative Code §§ 134.403(i) and (j) for performing this procedure in an alternative facility setting. Reimbursement is not recommended.
- Procedure code A6252 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(d)(1). The fee listed for this code in the Medicare DMEPOS fee schedule is $3.25. This amount multiplied by 2 units is $6.50. 125% of this amount is $8.13. Reimbursement is the lesser of the MAR or the provider's usual and customary charge of $2.00. The lesser amount is $2.00.
- Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1840 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1885 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405 has a status indicator of K, which denotes nonpass-through drugs and biologicals paid under OPPS with separate APC payment. These services are classified under APC 768, which, per OPPS Addendum A, has a payment rate of $0.26. This amount multiplied by 60% yields an unadjusted labor-related amount of $0.16. This amount multiplied by the annual wage index for this facility of 0.9997 yields an adjusted labor-related amount of $0.16. The non-labor related portion is 40% of the APC rate or $0.10. The sum of the labor and non-labor related amounts is $0.26. Per 42 Code of Federal Regulations §419.43(f) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, drugs, biologicals, and items and services paid at charges adjusted to cost are not eligible for outlier payments. The total Medicare facility specific reimbursement amount for this line is $0.26. This amount multiplied by 200% yields a MAR of $0.52.
- Procedure code J2795 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 93000 has a status indicator of B, which denotes codes that are not recognized by OPPS when submitted on an outpatient hospital bill. Reimbursement is not recommended.

4. The total allowable reimbursement for the services in dispute is $2,971.56. This amount less the amount previously paid by the insurance carrier of $291.84 leaves an amount due to the requestor of $2,679.72. This amount is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established by a preponderance of the evidence that additional reimbursement is due. As a result, the amount ordered is $2,679.72.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,679.72, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

| | Grayson Richardson | December 20, 2013 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.